



Provincial Health Services Authority

Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca/terms-of-use and according to acceptable standards of care.

PROTOCOL CODE: GOCXCAD

DOCTOR'S ORDERS			Ht _____ cm	Wt _____ kg	BSA _____ m ²
REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form					
DATE:	To be given:	Cycle #:			
Date of Previous Cycle:					
<input type="checkbox"/> Delay treatment _____ week(s) <input type="checkbox"/> CBC & Diff day of treatment May proceed with doses as written if within 96 hours ANC greater than or equal to 1.5 x 10⁹/L, platelets greater than or equal to 100 x 10⁹/L Dose modification for: <input type="checkbox"/> Hematology <input type="checkbox"/> Other Toxicity _____ Proceed with treatment based on blood work from _____					
PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____. dexamethasone 8 mg PO BID for 3 days, starting one day prior to each treatment; patient must receive minimum of three doses pre-treatment ondansetron 8 mg PO 30 minutes prior to CARBOplatin <input type="checkbox"/> aprepitant 125 mg PO 30 to 60 minutes prior to CARBOplatin If additional antiemetic required: <input type="checkbox"/> OLANzapine <input type="checkbox"/> 2.5 mg or <input type="checkbox"/> 5 mg or <input type="checkbox"/> 10 mg (select one) PO 30 to 60 minutes prior to CARBOplatin Optional: Frozen gloves starting 15 minutes before DOCEtaxel infusion until 15 minutes after end of DOCEtaxel infusion; gloves should be changed after 45 minutes of wearing. <input type="checkbox"/> Other:					
Have Hypersensitivity Reaction Tray and Protocol Available					
CHEMOTHERAPY: DOCEtaxel <input type="checkbox"/> 75 mg/m² or <input type="checkbox"/> 60 mg/m² (select one) x BSA = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg/m ² x BSA = _____ mg IV in 250 to 500 mL (non-DEHP bag) NS over 1 hour. (Use non-DEHP tubing) CARBOplatin AUC <input type="checkbox"/> 5 or <input type="checkbox"/> 4 (select one) x (GFR + 25) = _____ mg <input type="checkbox"/> Dose Modification: _____ % = _____ mg IV in 100 to 250mL NS over 30 minutes.					
RETURN APPOINTMENT ORDERS					
<input type="checkbox"/> Return in three weeks for Doctor and Cycle _____ <input type="checkbox"/> Last Cycle. Return in _____ week(s).					
CBC & Diff on <input type="checkbox"/> Day 7 <input type="checkbox"/> Day 14. CBC & Diff, creatinine prior to next cycle. Prior to next cycle, if clinically indicated: <input type="checkbox"/> total bilirubin <input type="checkbox"/> alkaline phosphatase <input type="checkbox"/> ALT <input type="checkbox"/> sodium <input type="checkbox"/> potassium <input type="checkbox"/> magnesium <input type="checkbox"/> calcium <input type="checkbox"/> CA 15-3 <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 19-9 <input type="checkbox"/> CEA <input type="checkbox"/> SCC <input type="checkbox"/> Other tests: <input type="checkbox"/> Consults: <input type="checkbox"/> See general orders sheet for additional requests.					
DOCTOR'S SIGNATURE:				SIGNATURE:	
				UC:	